VACCINE DOCUMENTATION/CONSENT FORM

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below. **My signature on this form is also an agreement to Elk County Health Dept's Notice of Privacy Practices (HIPPA).**

PATIENT INFORMATION

Patient's Last Name: Patient's First Name: Phone : Age: Birth Date:

Street Address: City: County State Zip code:

Ethnicity: Hispanic or Latino
_____ Yes _____ No
Gender
_____ Male _____ Female

Race: (Select one or more)

_____ Black or African American
_____ Caucasian
_____ NW-Other Non-White
_____ UN-Unknown

PRIMARY CARE PHYSICIAN:

CITY:

IMMUNIZATION SCREENING QUESTIONNAIRE

1. Did the person to be vaccinated receive the flu vaccine last year? _____ yes _____ no
2. Is the person to be vaccinated currently sick or experiencing a high fever? _____ yes _____ no
3. Has the person to be vaccinated had a serious reaction to flu vaccine in the past? _____ yes _____ no
4. Does the person to be vaccinated have any allergies to eggs? _____ yes _____ no
5. Is the person to be vaccinated pregnant or thinking of becoming pregnant in the next three months? _____ yes _____ no
6. Has the person to be vaccinated had a seizure or other neurological problems? _____ yes _____ no

_____ _____
Signature of Patient or Parent/Guardian Date

**********SECTION BELOW TO BE FILLED OUT BY HEALTH DEPARTMENT STAFF**********

Medicaid Number:_____ Medicare Number: _____
Medicaid Provider: Kan Care or Kansas Medicaid

Other Private Insurance: _____ BCBS Number: _____

VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER/LOT#		EXP DATE
Fluzone QV	1	RT LT	Deltoid	IM	8/6/2021	San/Past	UT 7680 NA	06/30/23
Fluzone HD	1	RT LT	Deltoid	IM	8/6/2021	San/Past	UT 7715 AA	06/30/23
Flublok	1	RT LT	Deltoid	IM	8/6/2021	San/Past	UJ893AB	06/09/23
VFC fluzone QV	1	RT LT	Deltoid	IM	8/6/2021	San/Past		
Pneumococcal 23		RT LT	Deltoid	IM		Merck		

_____ _____
Signature and Title of Vaccine Administrator Date